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	085020	A. BUILDING _____ B. WING _____	C 12/23/2010

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PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from December 9, 2010 through December 23, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-eight (138). The survey sample totaled forty-six (46) residents.	F 000	This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Pinnacle Rehab agrees with the allegation and citations listed on the statement of deficiencies. Pinnacle maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Pinnacle's written credible allegation of compliance. By submitting this plan of correction, Pinnacle does not admit the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation or position, and Pinnacle reserves the right to raise all possible contentions and defenses any civil or criminal claim, action or proceeding.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/21/11

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R199, R86, and R71) out of 46 residents sampled the facility failed to consult with the physician when there was a change in a resident's condition or a concern that required physician intervention. The facility failed to consult R199's physician when a physician ordered treatment could not be initiated. The facility failed to consult the physician when R86's interested family member inquired about R86 not having a finger stick blood sugar (FSBS) completed and requested a follow-up by the attending physician. R71 experienced signs and symptoms of hypoglycemia and the facility failed to consult R71's physician. Findings include: 1. On 11/19/10 the facility received laboratory results for R199 of BUN 30 (H mg/dl 10-26) and Na 161 (H meq/l 135-145). E24 (nurse practitioner) was made aware and ordered the resident be sent to the emergency room for evaluation. Nurses notes revealed that E4 (DON) was made aware of the order and called E3 (physician) and received an order to keep the resident in the facility and administer IV (intravenous) fluids. The IV order was dated 11/19/10 and timed 9 PM for D5 1/2 NSS at 60 ml/hr for 1 liter of fluid. A late entry nurse's note documented that the night	F 157	F157 A) 1) The Nurse Practitioner was notified on 11/20 of R199's IV bag not being started until 11/20/10. 2) R86 no longer resides in the facility as of 11/22/10. 3) R71 no longer resides in the facility as of 12/11/10. B) All residents with a change in condition has the potential to be affected by the deficient practice. An audit has been performed on the 24 hour reports to review and changes and proper physician notification. No other residents have been affected. C) Policy and guidelines for MD Notification of a change in condition have been reviewed and updated to ensure that the needs of the residents are being met timely and the MD is being given information related to changes. Nursing staff will be in serviced on the Policy for MD notification. The DON/or designee will review 24 hr report daily to ensure licensed staff is notifying MD. All changes in condition will be reviewed in daily clinical mtg.	3/11/11

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F 157	Continued From page 2 nurse was unable to gain IV access after two attempts. There was no evidence that the physician was notified that the IV could not be started. A nurse's note on 11/20/10 and timed 9 AM documented that the IV was started by the day shift supervisor. An interview on 12/23/10 with E4 (DON) and the E2 (Administrator) confirmed the lack of physician consultation. 2. R86 was readmitted to the facility on 11/8/10 from the hospital with diagnoses of pseudomonas pneumonia and clostridium difficile colitis. In addition, R86 had diagnoses including diabetes mellitus, congestive heart failure, and chronic obstructive pulmonary disease. Review of nurse's note dated 11/12/10 timed 12:20 AM revealed that R86's family member expressed concerns related to R86's food, finger stick blood glucose (FSBS), whether the doctor has been in, and side rails on the bed. The note documented that the 7 AM-3 PM shift will contact the family member related to the above concerns. In addition, the note documented that the family member requested call back from E3 (R86's attending physician) and that this request was referred to the 7 AM-3 PM shift. Record review, including the 24 hour shift report for 11/12/10 lacked evidence that E3 was consulted regarding the above concerns expressed by R86's family member which had the potential for requiring physician intervention. Review of the hospital history and physical dated 11/22/10 revealed R86 was admitted with	F 157	D) A random audit of 10% of resident charts will be conducted monthly times 3 months and reported at the monthly QA meeting.	3/11/11

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shortness of breath and blood glucose of 489 (normal range 70-110).

An interview with E3 (R86's attending physician) on 12/23/10 at 8 AM revealed that she was not made aware of concerns made by R86's family and if she was made aware, she would have ordered a FSBS minimally weekly.

Above findings reviewed with E2 (administrator), E4 (director of nursing), and E17 (corporate nurse) on 12/23/10 at approximately 2 PM.

3. Cross refer F309, example 1
R71 was admitted to the facility on 11/3/10 from the hospital following left above the knee amputation on 10/20/10. In addition, R71 had diagnoses including peripheral vascular disease, right above knee amputation, diabetes mellitus, coronary artery disease, hypothyroidism, and end stage renal disease (ESRD) on hemodialysis three times a week.

Review of nurse's note dated 12/3/10 timed 6 PM documented R71 was feeling dizzy at 4 PM and the FSBS was 64. R71 was given cranberry juice and the scheduled Prandin 2 mg. at 5 PM was held due to the FSBS of 64 and symptomology. Record review lacked evidence of a thorough assessment of dizziness including blood pressure and consultation with E3 (physician) relating to R71 symptom of dizziness which had the potential for requiring physician intervention.

Additional review of 12/4/10 MAR noted that R71's FSBS was 65 at 6 AM and that scheduled Prandin 2 mg. at 6 AM was held. Facility's "Meal Intake Detailed Report" documented that R71 was out of facility, thus, record review lacked

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F 157	Continued From page 4	F 157		

evidence that R71 had consumed any breakfast prior to dialysis. Review of "Renal Dialysis-Communication Form for Hemodialysis" dated 12/4/10 lacked evidence that the dialysis center was informed of the FSBS and/or the holding of the Prandin. However, the form did include from the dialysis center Registered Nurse that "BS (blood sugar) was 24 (on 12/4/10 at 11 AM) and R71 was given one ampule of D5 (Dextrose 50%) and repeat BS was 400.

Review of R71's "Treatment Sheet for Facility: (Name of the nursing home)" from the dialysis center noted that "at end of tx (treatment) pt (patient) was diaphoretic 25 ml (milliliter) of D50 given and pt. then beginning to arouse. At 11:30 a.m. was awake alert...repeat BS 400. (Name of nursing home) called regarding low BS (blood sugar)."

Review of nurse's note dated 12/4/10 timed 12:55 PM noted upon R71 returning to facility at approximately 12:05 PM, R71's FSBS was 110 and R71 reported that "I feel fine now but I passed out in dialysis." Note further documented at 1:10 PM, R71's FSBS was 64 and the 1 PM dose of Prandin 2 mg. was held. Record review lacked evidence that the physician was notified of above.

Nurse's note dated 12/6/10 timed 11:55 AM noted R71 complaining of light-headed, confusion and FSBS was 64. Resident was given apple juice and repeat FSBS was 77 with no further complaints of being light headed. Record review lacked evidence that E3 was informed of R71's symptomology of hypoglycemia of confusion and being light-headed.

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F 157	Continued From page 5 Nurse's note dated 12/6/10 timed 5 PM noted E3 (attending physician) was made aware of fasting blood glucose level (completed by laboratory services) of 55 and no new order was received. Nurse's note dated 12/7/10 timed 1:40 PM noted upon R71's return to facility, FSBS was 64 and scheduled Prandin was held for 1 PM. R71 exhibited no signs/symptoms of hypoglycemia. Although 6 AM Prandin 2 mg. was refused by R71 on 12/7/10 and 12/9/10 and the 1 PM Prandin on 12/6/10 was held by licensed nurse due to FSBS of 64 and R71's complaints of light headedness and confusion, record lacked evidence that the physician was consulted. An interview with E3 on 1/7/11 at approximately 9 AM revealed that if she was notified of the Prandin being refused or held in addition to R71's hypoglycemia symptoms and signs experienced on 12/3/10, 12/4/10, 12/6/10, and 12/7/10 as noted above, would have reassessed the current interventions.	F 157	F166 A) R86 no longer resides in the facility as of 11/22/10. B) All residents have the potential to be affected by this deficient practice. An audit of grievances has been reviewed by Social Services to determine timely response (5 days) to families or residents. No other residents have been affected. C) Requests from family members regarding resident's condition will be called into the Physician within 24 hours for follow up. All Licensed staff to be in serviced on new protocol, um/charge nurse to f/u with MD.	3/11/11
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve a grievance for one (R86) out of 46 sampled residents. Findings include:	F 166	D) A review of the 24 hour report/grievances will be completed by the DON/or designee weekly times 4 weeks to determine compliance. Results will be reported at the monthly QA meeting.	

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve a grievance for one (R86) out of 46 sampled residents. Findings include:	F 166	D) A review of the 24 hour report/grievances will be completed by the DON/or designee weekly times 4 weeks to determine compliance. Results will be reported at the monthly QA meeting.	

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F 166	Continued From page 6 Cross refer F157, example 2. R86 was readmitted to the facility on 11/8/10 from the hospital. Review of nurse's note dated 11/12/10 timed 12:20 AM revealed that R86's family member related to the facility that R86 has not had her finger stick blood glucose (FSBS) since readmission and that the family member requested a follow-up by E3 (R86's attending physician). Record review lacked evidence that the above grievance was followed-up by the facility.	F 166	F221 A) R199's "swaddling" was removed by E20 on 11/22/10 upon discovery. Resident suffered no ill effects from the "swaddling incident". B) The facility's practice is to use the least restrictive device and assess the resident's safety needs prior to the application of a potentially restrictive device. All resident's with positioning devices were reviewed to insure they were appropriate and not restricting movement or access to a resident's person. C) Staff Ed to in-service staff on what a restraint is and the process one must complete before obtaining an order for one. In-service will also be completed on Abuse, neglect and mistreatment. D) Daily Ambassador Rounds will be completed by management team to insure compliance with our Restraint policy. The Interdisciplinary team will review all	3/11/11
F 221 3S=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R199) out of 46 sampled residents the facility failed to ensure a resident was free from the use of physical restraints for the purpose of staff convenience. Findings include: A nurse's note dated 11/22/10 and timed 4:25 PM documented "resident continues to get OOB (sic) from Broda chair unassisted. Resident unable to be redirected due to progression of dementia. Resident sits in Broda chair with pressure alarm; alarm constantly sounding due to resident	F 221		

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F 221	Continued From page 7 scooting out of chair. Staff has to constantly run to resident's aid in attempts to prevent resident from injury. Resident got OOB (sic) from chair and placed one knee on the floor in a kneeling position. Resident assisted back to chair x 2 staff members. Resident has been toileted, offered fluids, verbal redirection attempted, but does not alter behaviors. Will continue to monitor". A facility reported incident report dated 11/23/10 documented that on 11/22/10 "blanket was placed on resident's lap in a manner that could have possibly prevented him from rising freely from Broda chair". Review of the facility's investigation revealed through staff statements that on 11/22/10 at around 3:35 PM E11 (nurse) placed a blanket around R199's lap and tucked it behind his back to swaddle him because he was fidgeting. E11 denied tying a knot in the blanket. E11 stated that he told E12 (unit manager) and the E20 (evening supervisor) about the blanket swaddling the resident. A statement by E20 (evening supervisor) documented that she went to the unit and removed a blanket for R199's lap that was wrapped around the arms of the resident's chair. A statement by E4 (DON) documented that she checked the blanket on R199's chair and found that it was tied to the left side of the chair. An interview on 12/23/10 with E4 revealed that she did not know E20 had loosened the sheet on the chair just before she identified the knot until she talked to E20 the next day. At that point it was identified as in inappropriate use of a restraint.	F 221	resident's positioning and safety devices monthly to insure they continue to be appropriate to meet the needs of the resident. The results will be brought forward to QA meeting for review monthly for the next 2 months and then quarterly thereafter.	

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F 221	Continued From page 8 There was no evidence that a physician order was obtained or a medical symptom was identified for the use of this restraint. There was no assessment or care plan in place to use physical restraints on R199. The facility's restraint policy stated "A licensed nurse may place an emergency restraint on a resident if it is determined that the restraint is necessary as the behavior presented by the resident places him or others in a situation where the potential for injury may occur". The only documented behavior for R199 was trying to get up unassisted requiring increased staff attention. Interview with E4 (DON) on 12/23/10 confirmed that the resident should not have been restrained with a bath blanket and staff discipline and re-education was conducted.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		

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F 225	Continued From page 9 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to immediately notify the state agency of an unwitnessed fall that had the potential for an allegation of neglect for one (R98) out of 46 residents sampled. Findings include: Cross refer F323 example #1 On 12/20/10 around 9:00 PM the nurses notes documented "12/20/10 at 10:00 PM Resident (R98) was found lying on his right side in front of his bed on the floor. Around 9:00 PM. Resident alert, verbally responsive, denied pain, neurocheck done WNL (within normal limits) no injury no bruises observed at this time."	F 225	F225 A) Incident was reported on 12/29/10 for R98. B) A review of all incidents for the past 30 days will be completed to ensure a complete investigation was done and corrections were made as necessary. C) All incidents are reviewed in clinical morning meeting to insure they have been completed correctly and reported per State reporting guidelines. In servicing will be done with Nursing staff related to incident Reporting. D) Audits will be completed for injuries if unknown origins/reportable weekly times 4 weeks. Results will be brought forward to the QA process for review and revision.	3/11/11

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F 225	Continued From page 10 Neurological assessments were completed on R98 from 12/20/10 at 9:00 PM through 12/21/10 at 6:30 AM with no concerns identified. Review of the incident with E2 (Administrator) on 12/29/10 at 11:10 AM confirmed the facility failed to notify the state agency of an allegation of neglect for R98's fall that required neurological assessments.	F 225	F246 A) R205 no longer resides in the facility. Resident was discharged on 12/22/10. B) All residents have the potential to be affected by this deficient practice including new admissions. All currently admitted residents will be interviewed for bathing preference times and accommodated accordingly. C) All new admissions will be interviewed during the admission (Nursing) assessment. Newly admitted residents will be accommodated with their bathing preference times. Nursing staff will be educated regarding resident preferences, needs and accommodations. D) A bathing preference audit will be completed on newly admitted residents weekly times 4 weeks. Results of this audit will be brought through the QA process for review and revision when necessary to ensure compliance.	3/11/11
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for R205 and many other undetermined residents the facility failed to ensure personal preference was a priority when establishing the bathing schedule. Findings include: A nurse's note in R205's record documented "12/13/10 0630 resident with increased agitation when asked and encouraged to get shower this am. Resident upset he was woke up, resident informed staff he would get shower when he was ready attempted x 2 to encourage to take the shower the resident refused". An interview on 12/17/10 at 3:40 PM with R205	F 246		

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F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for R205 and many other undetermined residents the facility failed to ensure personal preference was a priority when establishing the bathing schedule. Findings include: A nurse's note in R205's record documented "12/13/10 0630 resident with increased agitation when asked and encouraged to get shower this am. Resident upset he was woke up, resident informed staff he would get shower when he was ready attempted x 2 to encourage to take the shower the resident refused". An interview on 12/17/10 at 3:40 PM with R205	F 246	B) All residents have the potential to be affected by this deficient practice including new admissions. All currently admitted residents will be interviewed for bathing preference times and accommodated accordingly. C) All new admissions will be interviewed during the admission assessment. Newly admitted residents will be accommodated with their bathing preference times. Nursing staff will be educated regarding resident preferences, needs and accommodations. D) A bathing preference audit will be completed on newly admitted residents weekly times 4 weeks. Results of this audit will be brought through the QA process for review and revision when necessary to ensure compliance.	

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F 246	Continued From page 11 about his bath preference revealed that he took a shower at night when he lived at home. He further stated that he worked for many years and now he wants to sleep until he wakes up. Review of the aide documentation record noted that from admission 12/1/10 until his room change on 12/14/10, R205 was scheduled for a shower on the 11 PM to 7 AM shift on Mondays and Thursdays. An interview with E22 (nurse) on Aspen unit on 12/21/10 at 1:48 PM revealed that the bathing schedule was set up by room number. He further stated that it was not a practice to ask a resident when they would like a bath but if the resident complained about their schedule they would change the schedule. An interview with E23 (nurse) on the Seaside unit on 12/21/10 revealed that a new resident is put in an open bathing spot unless they verbalize a specific preference. Review of the shower schedule revealed that when R205 moved to Seaside on 12/14/10 he was placed on the 7 AM to 3 PM bathing schedule because that was the schedule for his assigned room. An interview on 12/22/10 with E7 (Sierra nurse) revealed that the bathing schedule is set up by room number. However, if a resident needs a lot of assistance they would be bathed when more staff are scheduled to work. She further stated that resident preference would be considered if the resident or family had a request.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 12 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that for two (R199 and R75) out of 46 residents sampled the facility failed to develop care plans for identified needs Findings include 1. R199 had a physician's order dated 11/25/10 for DNR (do not resuscitate), RN may pronounce, comfort measures, do not hospitalize except acute trauma no ivs, no peg tube, no routine labs. There was no care plan established for comfort care. 2. Review of R75's clinical record revealed he	F 279	F279 A) 1) A care plan was written on 12/27/10 to address R199's comfort measures. 2) A care plan was written on 12/14/10 to address R75's smoking safety. B) All residents have the potential to be affected by this deficient practice. An audit was conducted to determine other residents lacking appropriate care plans. No other residents were identified. C) Care plans will be updated daily during clinical meeting to ensure changes in status/new orders are captured. An audit of 10% of all resident's care-plans will be reviewed monthly times 3 months to insure compliance. D) Results of this audit will be brought through the QA process for review and revision when necessary.	3/11/11

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F 279	Continued From page 13 went outside to smoke. Review of R75's care plans with E7 (RN unit manager) confirmed the facility failed to develop a care plan for R75 with interventions to promote safety while smoking.	F 279	F280 A) 1) R98's Care plan was revised 12/16/10. 2) R25's Care plan was revised 12/16/10. 3) R71 no longer resides in the facility. B) All residents have the potential to be affected by the deficient practice. A review will be completed of all care plans to determine if reviews and revisions are required and updated as appropriate. C) Care plans will updated and revised daily as needed during Clinical meeting to ensure changes in status/new orders are captured. D) Upon complete review of all care plans, an audit will be conducted of 10% of Care Plans monthly times 3 months to ensure current clinical changes and conditions have been addressed. Outcomes will be reported at the monthly QA meeting.	3/1/11
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise the plan of care for three (R98, R25, and R71) out of 46 residents sampled. Findings include:	F 280		

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F 280	Continued From page 14 Cross refer F314 1. Review of R98's clinical record revealed that he was readmitted to the facility on 1210/10 with a purple heel with possible deep tissue injury. On 12/20/10 at 9:30 AM observation of R98's skin was made with E6 (wound nurse). The outer and inner aspect of R98's right heel was purple with possible deep tissue injury. Review of R98's care plan dated 11/3/10, that was revised on 12/16/10, and record revealed the facility failed to review and revise R98's care plan with interventions addressing R98's right purple heel. 2. R25 was originally admitted to the facility on 7/12/07 with diagnoses including cerebral vascular accident, diabetes mellitus, hypertension, depression, and urinary retention. Review of the facility's "Wound Flow Sheet" for December 2010 for R25 noted presence of two pressure ulcers (PU); unstageable right ischial (initial date identified on 12/3/10) and stage II, right inner buttock (initial date identified on 12/2/10) with most recent assessments on 12/15/10. Review of R25's care plans on 12/15/10 revealed a care plan for risk of developing a PU implemented on 12/3/10, however, no care plan for the above actual PUs and the corresponding interventions. Subsequent review of care plans on 12/17/10 revealed that the facility implemented an actual PU care plan on 12/16/10 for right buttock and right ischial pressure ulcer and failed to revise the above care plan for the risk of developing a PU. Interview with E6 (Facility's	F 280		

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F 280	Continued From page 15 wound care nurse/Registered Nurse) on 12/17/10 at 10 AM confirmed that there was no care plan for both of the PUs until 12/16/10 at which time, actual care plans of the PUs were implemented. Above findings reviewed with E2 (administrator), E4 (director of nursing), and E17 corporate nurse on 12/23/10 at approximately 2 PM. 3.Cross refer F309, example 1. R71 was admitted to the facility on 11/3/10 with a change in mental status, peripheral vascular disease, bilateral above knee amputation, diabetes mellitus, coronary artery disease, hypothyroidism, and end stage renal disease (ESRD) on hemodialysis. Review of "Nutritional History" completed by the E8 (Registered Dietician) dated 11/8/10 noted R71's current weight of 114.5 pounds (#). The nutritional summary noted R71 was at increased nutritional risk secondary to ESRD with therapeutic diet and that R71 requests Nepro as "it helps with her appetite." Review of care plan titled "Nutrition" implemented on 1/8/10 included goal of R71's weight will remain +/- five # of current weight through next review of 2/8/11. Approaches included: - weigh and monitor results - Refer for a screen as needed to E8 - Nepro (nutritional supplement) three times a day - Sandwich at bedtime - Report to nurse any signs/symptoms of chewing/swallowing or other problems consuming meals: Eats less than 50 % of meal Review of care plan implemented on 11/7/10 for	F 280		

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F 280	Continued From page 16 "hyperglycemia/hypoglycemia " noted that R71 was at risk for complications associated to hyper/hypoglycemic related to diagnosis of non-insulin dependent diabetes mellitus, renal failure/dialysis. Goals on care plan included: - Will remain free of complications related to hyper or hypo glycemia through the next review date of 2/7/11. - R71 will remain free of complications related to hyper or hypo glycemia through the next review date of 2/7/11. - R71's blood sugar and other lab values will be within acceptable parameters according to physician Approaches included: - Monitor for s/s (signs and symptoms) of unstable blood levels including tremors, shaking, confusion, headache, irritability, hunger, nausea/vomiting; cool, clammy, pale skin; and sweating -Perform Accuchecks as ordered -Monitor intake of meals. Offer substitutes, supplements, or alternate choice as needed and allowed - Review weight weekly and notify physician and RD of significant gain or losses. Although R71's meal consumption was less than 50 % for majority of the meals, the facility failed to reassess the approaches for the above care plan for nutrition. Additionally, even though R71 had symptoms of hypoglycemia including confusion, light headedness, the facility failed to reassess the approaches in the care plan for complications related to hypoglycemia.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 17 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to follow their plan of care in notifying the proper person to supply care and services for two (R98 and R95) out of 46 residents sampled. After receiving pain medication R98s had complaints of pain he voiced to E6 (wound nurse) who failed to notify the primary nurse of the complaint. R95 had a care plan for falls that included interventions that the CNAs normally provided, however these interventions were not communicated to the CNAs. Findings include: 1. Review of R98's record revealed he was readmitted from the hospital on 12/10/10 with an unstageable sacral pressure ulcer. On 12/21/10 at 8:30 AM E10 (nurse) administered pain medication to R98. On 12/21/10 at 9:30 AM the surveyor went to R98's room with E6 (wound nurse). R98 complained he was in pain. E6 stated she would talk to his primary nurse. A few minutes later E6 (wound nurse) returned to R98's room and stated E10 (primary nurse) gave resident Extra Strength Tylenol at 8:30 am this morning. E6 continued to state she would talk to the primary nurse about calling the physician for more pain medication.	F 282	F282 A) 1) R98's pain medication was adjusted immediately on 12/12/10. 2) R95 no longer reside: in the facility as of 11/06/10. B) All residents have the potential to be affected by this deficient practice. A audit was conducted on residents with pain medication to ensure effectiveness of regime. No other residents were affected by this deficient practice. An audit was completed of all CNA communication Cardex's and any revisions were made as needed. C) 1)Pain assessments will continue be completed prior to administration of PRN medication and within 30 minutes to 1 hour post pain medication to ensure adequate pain control for all residents. Licensed personnel will be re-educated on pain assessment and protocol.	3/11/11

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F 282	Continued From page 18 An interview with E10 (nurse) on 12/21/10 at 9:50 AM concerning R98's pain revealed she was not notified that R98 was still in pain. She continued to state E6 (Wound Nurse) only wanted to know if R98 received pain medication and the name of the pain medication. At 9:58 AM E10 received an order for Tylenol #3 every 3 hours as needed and administered the medication to R98 before the resident left for dialysis. 2. Cross refer F323 example #2 R95 was admitted to the facility with diagnoses that included congestive heart failure, diabetes mellitus, post subarchanoid bleed from a fall, and a pacemaker. On 10/12/10 R95 had a physician order for fall mats down on floor while in bed, alarms to his bed and chair. Review of R95's care plan dated 10/11/10 and revised on 10/12/10 for "At risk for fall related injury as evidence by previous fall related to disease process/condition interventions 10/12/10 fall mats, alarms to bed and chair." Review of the CNAs' communication Carddex for R95 revealed there was no documentation indicating the CNAs' were informed on the interventions of fall mats and alarms to R95's chair and bed as ordered by the physician. Review of R95's Treatment Administration Record and the CNAs' documentation revealed their was no evidence indicating that fall mats and alarms were in place for R95. Review of R95's clinical record with E2 (DON) on 12/17/10 at 9:45 AM confirmed there was no	F 282	2) Nursing personnel will cross reference through 24hr chart check all new orders to ensure that those orders are transcribed correctly and appropriately to the MAR/TAR/CNA data sheets. D) An audit of 10% of resident charts will be reviewed monthly times three months to ensure compliance of effectiveness of pain regime and accurate transfer of orders. Results will be reported at the monthly QA meeting.	3/11/11

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F 282	Continued From page 19 documentation indicating the CNAs were made aware of the interventions of fall mats and alarms for R95.	F 282	F309 A) Resident R71 no longer resides in the facility as 12/11/10. B) All residents have the potential to be affected by this deficient practice. An audit was conducted through CareTracker of meal consumptions. An audit was conducted on the MAR's on all three units of diabetic residents and Blood glucose levels to ensure residents were asympotamatic of hypoglycemia. No residents were affected at the time of audit and no revision(s) in the plan of care applicable. C) 1). Nursing staff will be educated on monitoring food intake. ADON or designee will monitor meal consumption daily through CareTracker and will notify Unit Managers if consumption of meals are below requirements for those residents identified. Unit managers will notify CNA's, MD, and RD of decreased meal consumptions and will update the Plan of care as indicated 2). Licensed personnel will be educated on the importance of notifying the physician in the event of residents who are identified as being symptomatic of hypoglycemia.	3/11/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (R71) out of 46 residents sampled. The facility failed to monitor R71's meal consumption of less than 50%, failed to assess R71 who had several episodes of decreasing FSBS (Finger Stick Blood Sugar) levels, failed to notify the physician, and failed to revise R71's plan of care. Due to the lack of physician notification, the physician was not consulted for her interventions even after R71 experienced two severe hypoglycemic episodes (Target blood glucose ranges for those individuals with diabetes, 70 to 130 mg/dL; Source: American Diabetes Association. Standards of Medical Care in Diabetes-2008. Diabetes Care. 2008;31:S12-S54) while receiving hemodialysis. On 12/4/10, R71 became less responsive and the blood glucose	F 309		

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F 309	Continued From page 20 level in dialysis was 24 mg/dl and required administration of two doses of Dextrose 50 %. On 12/11/10, R71 experienced a second episode of severe hypoglycemia in which her blood glucose was 30 mg/dl and required administration of dose of Dextrose 50 %. Resident stated she passed out in dialysis. Findings include R71 was admitted to the facility on 11/3/10 from the hospital following left above the knee amputation on 10/20/10. In addition, R71 had diagnoses including peripheral vascular disease, right above knee amputation, diabetes mellitus, coronary artery disease, hypothyroidism, and end stage renal disease (ESRD) on hemodialysis three times a week (Tuesday, Thursday, and Saturday). Admission Minimum Data Set (MDS) assessment dated 11/23/10 documented that R71 had no cognitive impairment and was independent in daily decision making. Review of admission orders dated 11/3/10 revealed R71 was ordered Prandin 2 mg. po (by mouth) TID (three times a day) with meals (Patients who skip a meal should be instructed to skip a dose for that meal. Novo Nordisk, Product Insert, 2010). On 11/7/10, clarification orders were received and signed by E3 (R71's attending physician) which included: -Prandin 2 mg. po BID (twice a day) with meals at 7:30 AM and 12:30 on non-dialysis days. -Prandin 2 mg. po BID with meals at 6 AM and 1 PM on dialysis days. -Prandin 2 mg. po at 5 PM daily. Review of "Nutritional History" completed by E8	F 309	Attending physicians will be notified of blood glucose levels falling below parameters set forth by the attending physician or if a resident becomes symptomatic and will update the Plan of care as indicated. D) 1) On-going audits on CareTracker reports will be conducted weekly to ensure compliance. 2) A random audit will be conducted of 10% of diabetic residents weekly times 8 weeks. Outcomes and results will be reported at the monthly QA meeting. .	3/11/11

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F 309	Continued From page 21 (Registered Dietician) dated 11/8/10 noted R71's current weight of 114.5 pounds (#). The nutritional summary noted R71 was assessed at increased nutritional risk secondary to ESRD and on therapeutic diet. Additionally, R71 requested Nepro (therapeutic nutrition specifically designed to help meet the needs and altered metabolism of patients on dialysis) as "it helps with her appetite." Review of care plan titled "Nutrition" implemented on 11/8/10 included goal of R71's weight will remain +/- five # of current weight through next review of 2/8/11. Approaches included: - Weigh and monitor results - Refer for a screen as needed to E8 - Nepro three times a day - Sandwich at bedtime - Report to nurse any signs/symptoms of chewing/swallowing or other problems consuming meals: Eats less than 50 % of meal In addition, the care plan for "hyperglycemia/hypoglycemia " implemented on 11/7/10 noted that R71 was at risk for complications associated to hyper/hypoglycemic related to diagnosis of non-insulin dependent diabetes mellitus and renal failure/dialysis. Goals on care plan included: - R71 will remain free of complications related to hyper or hypo glycemia through the next review date of 2/7/11. - R71's blood sugar and other lab values will be within acceptable parameters according to physician Approaches included: - Monitor for s/s (signs and symptoms) of unstable blood levels including tremors, shaking, confusion, headache, irritability, hunger,	F 309		

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nausea/vomiting; cool, clammy, pale skin; and sweating
-Perform Accuchecks as ordered
-Monitor intake of meals. Offer substitutes, supplements, or alternate choice as needed and allowed
- Review weight weekly and notify physician and RD of significant gain or losses.

Review of meal consumption record from 11/5/10 through 11/30/10 (26 days) revealed that R71 consumed less than 50 % of her meal for the respective meals:
-Breakfast: 22 out of 26 meals (85%; Out of the 26 breakfast, 11 meals were documented as "OOF" or out of facility when R71 out of the facility at the dialysis center, thus, no percentage was documented)
-Lunch: 16 out of 26 meals (61%)
-Dinner: 10 out of 26 meals (38%)

Record review revealed admission weight of 114.5 #, however, record review lacked evidence of additional weights in November 2010. In addition, record review lacked evidence that the facility monitored R71's above meal consumption of less than 50% and failed to reassess the current interventions. It is unclear from facility documentation how the facility monitored and evaluated R71"s food intake in relation to the administration of Prandin.

Interview on 12/21/10 at 2:15 PM with E25 (Registered Nurse) reported on occasion, R71's family brought in meals for R71. Additional interviews with E29 and E30 (certified nursing assistants/CNAs) on 12/21/10 at 2:30 PM revealed that they recalled that R71's family rarely brought in meals for the resident and if the

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resident ate the meal brought in, this would be documented in the meal consumption record. In addition, both aides reported that they would notify the nurse if the resident refused a meal or ate less than 25 % but they do not recall that they needed to notify the nurse if R71 ate less than 50% of the meal.

On 12/1/10, R71 was evaluated by E34 (general vascular and thoracic surgeon) following the left above the knee amputation (LAKA). The LAKA was debrided and R71 was ordered Bactrim DS one po BID for 10 days. Subsequently on 12/2/10, E3 ordered the Bactrim DS daily for 10 days and R71 began receiving the Bactrim on 12/2/10. (Reference: Rxlist.com. "Drug Interactions: Like other sulfonamide-containing drugs, BACTRIM potentiates the effect of oral hypoglycemics"). Review of care plan for risk for complications associated to hyper/hypoglycemic failed to include that R71 was initiated on Bactrim DS.

Review of meal consumption record from 12/1/10 through 12/10/10 (10 days) revealed that R71's consumption continued to decrease with R71 consuming less than 50 % for 8 out of 10 for breakfast, 9 out of 10 for lunch, and 2 out of 10 for dinner. Record review lacked evidence that the facility monitored R71's meal consumption of less than 50% and failed to reassess the current interventions.

Record review revealed one additional weight on 12/2/10 of 112.2# and a post dialysis weight from the dialysis center on 12/7/10 of 116 #.

Nurse's note dated 12/3/10 timed 6 PM documented R71 was feeling dizzy at 4 PM and

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the FSBS was 64 and resident was given cranberry juice. Record review lacked evidence of a repeat FSBS and/or reassessment of R71. The scheduled Prandin 2 mg. at 5 PM was held due to the FSBS of 64 and symptomology. Record review lacked evidence that the physician was consulted relating to the dizziness or the need to hold the Prandin. Review of meal consumption for this day's breakfast and lunch noted R71 consumed 25 % of the meal for both meals and for dinner, R71 consumed 100 % of her meal.

Review of 12/4/10 MAR noted that R71's FSBS was 65 at 6 AM and that scheduled Prandin 2 mg. at 6 AM was held. Facility's meal record documented for breakfast, that R71 was "OOF" (out of facility), thus, record review lacked evidence whether R71 consumed her breakfast or not. Record review including the "Renal Dialysis-Communication Form for Hemodialysis" dated 12/4/10 lacked evidence that the dialysis center was informed of the FSBS and/or the holding of the Prandin. However, the form did include information from the dialysis center's Registered Nurse that "BS (blood sugar) was 24 (11 AM) and was given one ampule of D5 (Dextrose 50%) and repeat BS was 400. Review of meal consumption record for breakfast noted "OOF", thus, facility failed to document if R71 consumed breakfast.

Review of R71's "Treatment Sheet for Facility: (Name of nursing home)" dated 12/4/10 from the dialysis center noted that "at end of tx (treatment) pt (patient) was not very responsive and was diaphoretic 25 ml of D50 given with min. (minimum) results. At 11:10 AM, still diaphoretic and not very responsive, BS 45, another 25 ml

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F 309	Continued From page 25 D50 given, pt. then beginning to arouse. At 11:30 a.m. was awake alert...repeat BS 400. (Name of nursing home) called regarding low BS." Review of nurse's note dated 12/4/10 timed 12:55 PM documented upon R71 returning to facility at approximately 12:05 PM, R71's FSBS was 110 and R71 reported that "I feel fine now but I passed out in dialysis." The note further documented at 1:10 PM, R71's FSBS was 64 and the 1 PM dose of Prandin 2 mg. was held. Record review lacked evidence that the physician was notified of the above severe hypoglycemic episode. Review of meal consumption record for lunch and dinner noted 25% and 75% respectively. Nurse's note dated 12/6/10 timed 11:55 AM noted R71 complaining of light-headed, confusion and FSBS was 64. Resident was given apple juice and repeat FSBS was 77 with no further complaints of being light headed. Meal consumption noted R71 consumed 50 % of breakfast and lunch on 12/6/10. Nurse's note dated 12/6/10 timed 5 PM noted E3 (physician) was made aware of fasting blood glucose level (completed by laboratory services) completed on 12/6/10 of 55 and no new order was received. Nurse's note dated 12/7/10 timed 1:40 PM noted upon R71's return to facility from dialysis, FSBS was 64 and scheduled Prandin was held for 1 PM. R71 exhibited no signs/symptoms of hypoglycemia.	F 309		

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Although the 6 AM Prandin 2 mg. was refused by R71 on 12/7/10 and 12/9/10 and the 1 PM Prandin dose was held by licensed nurse due to FSBS of 64 and R71's complaint of light headedness and confusion, record lacked evidence that the physician was consulted.

Review of the MAR for 12/11/10 lacked evidence that the 6 AM FSBS was obtained prior to R71 going to dialysis and that R71 was administered the 6 AM Prandin 2 mg. Telephone interview with E33 (Licensed Practical Nurse) who worked the 11 PM - 7 AM shift on 12/11/10 revealed that she recalled that R71's FSBS was in the "low 70's" at 6 AM. E33 further related that she gave R71 couple of orange juices in case R71 experienced any symptoms of hypoglycemia during her shift, however, R71 did not experience any symptom of hypoglycemia. E33 indicated that the 11 PM-7 AM staff would obtain R71's breakfast from the kitchen which usually consisted of bowl of cereal, banana, and two juices. In addition, that the aides would document this in the meal consumption computerized system.

Meal consumption record for breakfast noted "out of facility", thus, record lacked evidence of what R71 consumed.

Review of R71's "Treatment Sheet for Facility: (Name of Facility) from the dialysis center dated 12/11/10 noted that "Pt. random blood sugar was 30 at 11:15 AM and pt. was given 25 ml of dextrose per standing order. Follow-up blood sugar at 11:25 AM was 235.

Review of nurse's note dated 12/11/10 (not timed) noted R71 alert and oriented. Fingerstick after arrival was 39. Stabilized resident and BS was 63

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F 309	Continued From page 27 after 15 minutes check. R71 had Nephro and 25% of lunch. Rechecked BS at 1 PM and was 67. Encouraged resident to eat lunch at 2:30 PM and BS was 75. Called E24 (Nurse Practitioner) and is aware. Will continue to monitor. MAR lacked evidence whether the Prandin was administered at 1 PM. Interview with E3 on 12/23/10 at approximately 8 AM revealed that she was made aware of the blood sugar of 55 on 12/6/10, however, it was her assessment no changes in R71's medication were needed. During this interview, E3 was informed of R71's meal consumption of less than 50 % and E3 related that the facility should have reassessed the interventions for nutrition. During this interview, the surveyor reviewed the FSBS from November 2010 compared to December 2010 and E3 indicated that the FSBS was trending down (blood sugar levels decreasing). Subsequent interview with E3 on 1/6/11 at approximately 9 AM revealed that if she was notified of the Prandin being refused or held in addition to R71's hypoglycemia symptoms and signs experienced on 12/3/10, 12/4/10, 12/6/10, and 12/7/10 as noted above, she would have reassessed the plan of care for R71. Despite R71's FSBS were decreasing and R71 had two severe hypoglycemic episodes in which her blood glucose was 24 and 30 (requiring medical treatment), the plan of care and the interventions remained unchanged.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 28 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of the facility's policy and procedures it was determined that the facility failed to provide care and services to promote healing for one (R98) out of 46 Residents sampled who had pressure ulcers and black heels. Findings include: The facility's policy and procedures for " Pressure Ulcers/Skin Breakdown-Clinical Protocol: documented "2....the nurse shall assess and document/report the following: b. full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue." The facility's policy and procedures for "Prevention of Pressure Ulcers" documented "5.c. When in bed, every attempt should be made to 'float heel' (keep heels off of the bed)... 6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed." R98 was admitted to the facility with diagnoses	F 314	F314 A) R98's care plan was revised on 12/16/10 and additional interventions were implemented including an air and perimeter mattress placed on the bed. R98 has preventative measures in place to promote wound healing and prevention as of 12/28/10, subsequent to readmission from an acute care hospital stay. B) All residents have the potential to be affected by this deficient practice. An audit will be conducted on all three units based on the Braden Assessment Score to identify those residents at high risk for developing skin breakdown. C) Nursing staff to be educated on procedures regarding weekly skin checks with appropriate documentation including assessments and measurements. The wound care nurse will make rounds weekly with the DON or ADON. The attending physician will be notified if the wound deteriorates or if there is no improvement within two weeks of the same treatment regimen. The attending physician will view any wound(s) that increases to greater than a stage II.	3/11/11

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F 314	Continued From page 29 that included congestive heart failure, coronary artery disease with a coronary artery bypass graft, pulmonary hypertension, diabetes mellitus type II, end stage renal failure hemo-dialysis, lower limb amputation below knee, gout, anemia, chronic airway obstruction, depression, and chronic pain. Review of R98's MDS dated 11/10/10 documented R98 required extensive assistance with two person assist with bed mobility, transfers, toilet use and personal hygiene. R98's MDS dated 12/6/10 documented he required extensive assistance with two person assist with bed mobility and one person physical assist with personal hygiene. Review of R98's weekly skin assessment sheet documented on 11/3/10 his skin was intact. On 11/10/10 the weekly skin sheet documented a stage II wound which was noted on the left side of his sacrum. The 11/22/10 skin sheet documented a circle drawn on the left buttocks area with a note "treatment in progress" but also had checked that "skin is intact" (12 days later instead of weekly). On 11/18/10 the nurses notes documented "a small open area noted to right buttock measuring .5 x.6 cm. No drainage noted. notified wound nurse who assess area. She applied hydrocolloid dressing to area which is to be changed q (every) 72 hours." Review of the wound sheets failed to have documentation that this wound was assessed weekly. However, the nurses notes and Treatment Administration Record documented that treatments were done every 72 hours. R98 was readmitted to the facility on 12/10/10	F 314	D) An audit of wound care documentation will be conducted weekly times 12 weeks of any resident with a pressure ulcer. Outcomes and results will be reported at the monthly QA meeting to ensure compliance.	3/11/11

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F 314	Continued From page 30 with diagnoses that included unstageable right sacral pressure ulcer, left hip stage II pressure ulcer, and black heels. Review of R98's care plan dated 11/3/10 for at risk for developing a pressure ulcer was reviewed and revised on 12/16/10 "R98 has pressure ulcers Left hip stage II and left buttocks unable to determine" that documented under approaches "Consult/make referral for screen PRN: wound nurse, complete weekly skin check, Heel/elbow protectors, Float heel when in bed." Review of R98's record lacked evidence indicating the left side sacral wound or the right buttock wound were consistently measured or assessed weekly. There was no evidence indicating R98's heel was being monitored or assessed by the wound nurse or the physician. On 12/21/10 at 8:30 AM R98 was observed in bed lying on his right side. His heel was not off loaded. R98 did not have a heel protector on. On 12/21/10 at 9:30 AM E9 (CNA) and E6 (wound nurse) observed R98 in bed lying on his right side. E9 and E6 confirmed R98's heel was not off loaded and he did not have a heel protector on. On 12/22/10 at 8:25 AM review of R98's clinical record with E1 (Corporate Nurse) and E4 (DON) confirmed the facility failed to consistently do weekly skin assessments. They continued to confirm that the facility failed to perform and document consistently weekly wound assessments per their procedure for R98's sacral and hip wounds. The facility also failed to monitor and document interventions with evaluations for	F 314		

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F 314	Continued From page 31 R98's black heel. On 12/22/10 at 8:55AM during a telephone interview with E3 (medical director/primary physician) confirmed she failed to observe and assess R98's sacral wound and hip wound even though she signed orders for the treatments of the wounds. An Interview with E5 (ADON also a certified wound nurse) on12/23/10 at 10:40 AM revealed the facility's procedure for wound assessments included weekly measurements and assessments of the wounds that was to be documented on the facility's wound sheets. E5 continued to state the wound nurse should have assessed the wounds weekly and notified her (E5) of any concerns.	F 314	F323 A) 1) R98 was not injured due to roll from bed. All safety measures have been implemented in accordance with R98's plan of care. 2) R95 no longer resides in this facility as 11/06/10. B) All residents who are dependent on care have the potential to be affected by this deficient practice. A review has been conducted of all residents whose fall risk score indicates a high risk. Safety measures will be implemented accordingly and appropriately as assessed by the IDT for residents scored as a high risk. C) Direct care staff will be educated on safety measures including proper positioning and safety measures while caring for dependant residents. D) An audit of 10% of all residents assessed to be at high risk for falls will be reviewed monthly times 3 months to ensure compliance to determine if safety measures are implemented appropriately. All results will be reported at the monthly QA meeting.	3/1/11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to ensure that two (R98 and R95) out of 46 residents sampled had an environment free from accident hazards and received adequate supervision to prevent falls and reduce injury. R98 fell out of bed when the CNA who had been providing care	F 323		

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left the resident unsupervised when she called for the nurse. R95 was care planned for fall mats and alarms that were not put in place. Findings include:

1. R98 was re-admitted to the facility on 11/6/10 with diagnoses that included congestive heart failure, coronary artery disease with a coronary artery bypass graft, pulmonary hypertension, diabetes mellitus type II, end stage renal failure hemo-dialysis, and lower limb amputation below knee.

Review of R98's MDS dated 11/10/10 documented R98 required extensive assistance with two person assist with bed mobility, transfers, toilet use and personal hygiene. R98's MDS dated 12/6/10 documented he required extensive assistance with two person assist with bed mobility and one person physical assist with personal hygiene.

Review of R98's care plan dated 12/3/10 for "At risk for fall related injury" with approaches that included "Provide environmental adaptations: Low/platform bed, call light within reach, ..."

Review of the incident report E16 (CNA) documented "On the above date (9/20/10 timed at 9:00 PM) I was giving (R98) a bed bath. I went to inform the nurse when I was done so she could do his treatment. I turned my head for one second and he was moving his legs and fell out the bed. Upon assessment by the nurse he was put back in bed with no pain at that time." The incident report continued to document " ACTION PLAN: Fall mats".

An interview with E13 (Rehab Director), E14

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(Physical Therapist) and E15 (Physical Therapist assistant) on 12/21/10 1030 AM revealed R98 did not initiate movement while in bed . E13, E14, and E15 all stated R98 would not change his position even if the position he was in had him in pain. They continued to state R98 was physically dependent on staff to move him.

An interview with E15 (Physical Therapy Aid) on 12/21/10 at 10:45 AM revealed E15 evaluated R98 yesterday (12/20/10) morning before he went to dialysis. E15 stated R98 did not move himself and was fully dependent on staff for movement in bed . R98 could not move himself or participate in movement as of yesterday morning.

On 12/22/10 at 11:40 AM a telephone interview with E16 (CNA) revealed she gave R98 a complete bed bath instead of a shower because he was complaining of pain. When E16 was finished she turned him on his side left and went to the door to call for R98's nurse so the nurse could assess his wounds. When she turned back around R98 fell out of the bed to the floor.

On 12/20/10 at 9:30 AM R98 was observed with E6 (wound nurse) and E9 (CNA) in bed laying on his right side. R98 had contracture's of his knees keeping them bent even when he was rolled side to side. E6 elevated R98's bed then E9 began cleaning him. E6 left the room with the bed in the elevated position to talk to the primary nurse. E9 left the room with R98's bed in the elevated position and unattended to get a basin of water.

On 12/20/10 around 9:00 PM the nurses notes documented. "12/20/10 timed at 10:00 PM Resident (R98) was found lying on his right side in front of his bed on the floor. Around 9:00 PM.

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Resident alert, verbally responsive, denied pain, neurocheck done WNL (within normal limits) no injury no bruises observed at this time." Neurological assessments were done from 12/20/10 at 9:00 PM through 12/21/10 at 6:30 AM with no concerns identified.

The facility failed to ensure that R98's environment was free from accident hazards and failed to follow the plan of care for falls for R98. Staff failed to lower his bed before leaving him unattended.

2. R95 admitted to the facility on 10/8/10 with diagnoses that included congestive heart failure, diabetes mellitus, post subarchanoid bleed after a fall, and a pacemaker.

Review of R95's physician orders revealed on 10/12/10 the physician wrote an order "2. fall mats down on floor while in bed, 3.alarms to bed and chair 4.grab bars to aid in movement."

Review of R95's care plan dated 10/11/10 that was revised on 10/12/10 for "At risk for fall related injury as evidence by previous fall related to disease process/condition" documented "interventions 10/12/10 fall mats, alarms to bed and chair."

Review of the CNA communication Carddex for R95 revealed there was no documentation indicating the CNAs were informed on the interventions of fall mats and alarms to R95's chair and bed.

Review of R95's Treatment Administration Record and CNA communication sheets revealed their was no documentation indicating that fall

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F 323	Continued From page 35 mats and alarms were in place for R95 from 10/8/10 through 11/6/10. Review of R95's incident report related to an 11/6/10 fall revealed "action plan(s) therapy to screen, add alarms and helmet upon return from hospital" Review of R95's physician order dated 11/9/10 revealed "Fall mats to bilateral bedside while in bed 2. Alarms to bed and chair, check placement and function every shift. 3. Grab bars to bed to aide in movement." This is similar to the physician order written on 10/12/10. Review of R95's clinical record with E2 (DON) on 12/17/10 at 9:45 AM confirmed there was no evidence indicating R95 had alarms to his bed and chair or fall mats were down on floor by his bed as ordered by the physician.	F 323	F327 A) R199 transitioned to Palliative care as of 11/25/10. B) All residents who are dependant for meals and fluids have the potential to be affected by this deficient practice. An audit was conducted through CareTracker of meal and fluid consumptions. No other residents were identified to be affected by this deficient practice.	3/11/11
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R199) out of 46 residents sampled the facility failed to ensure that adequate hydration was maintained. The facility failed to identify the residents lack of food and fluid intake resulted in no new interventions being developed to monitor intake and increase fluid consumption. Findings include:	F 327		

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F 327	Continued From page 36 R199 was admitted to the facility on 10/20/10 with diagnoses which included change in mental status, coronary artery disease, Alzheimer's dementia, hypertension, hypercholestremia, benign prostatic hypertrophy, and reflux. The nutritional evaluation dated 10/28/10 documented the resident's admission weight at 155 pounds and estimated fluid needs at 2100 ml per day. The resident's diet was regular pureed with honey thick liquids. The resident's care plan for nutrition initiated 10/28/10 included the approaches weigh and monitor results weekly, provide diet as ordered, provide/monitor intake of diet/fluids, and offer substitutes for 50% or less is consumed. No updates were made to the care plan as of 12/22/10. The resident's 14 day MDS dated 10/30/10 indicated the need for extensive assistance with one person physical assist for eating. Review of the ADL worksheet for October 2010 documented food acceptance. Of the 34 documented opportunities, R199 consumed 25% or 0 for 20 opportunities and 50% for 5 opportunities. There was no documentation available for specific fluid intake. An interview with a E1 (corporate nurse) on 12/22/10 revealed that the facility does not do intake and output monitoring on residents unless it is physician ordered or if the resident is on a fluid restriction. An interview with the E4 (DON) on 12/22/10 revealed that meal consumption and fluid intake	F 327	C) Staff will be educated on Food/Fluid intake. ADON or designee will monitor meal and fluid consumption daily through CareTracker and will notify Unit Managers if consumption of meals and fluids are below requirements for those residents identified. Unit managers will notify CNA's, MD, and RD of decreased fluid and meal consumptions and will update the Plan of care as indicated D) A random audit will be completed on 10% of residents per unit weekly times 4 weeks. Outcomes and results will be reported at the monthly QA meeting. .	3/11/11

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is monitored daily by the E5 (ADON). If a resident does not consume 50% of meal or fluid the unit manager is made aware.

Starting 11/1/10 the facility began capturing fluid intake on all residents with the initiation of computer charting. R199's fluid intake in November 2010 never reached the 2100 cc per day. Between 11/1 and 11/20/10 R199 was documented as drinking 720 cc or less for 14 out 20 opportunities and less the 1000 cc on all 20 days.

The resident was ordered weekly weights for the first four weeks in the facility. The weight for week two was unavailable. The weight for week three was done on 11/7/10 and was 148.1 pounds (4.5% weight loss). There was no evidence that the facility identified this weight loss or initiated any interventions for nutrition or hydration approaches related to this weight loss. The weight for week four was done on 11/13/10 at 145.5 pounds (6.1% weight loss). The dietitian added ensure plus bid on 11/15/10 in response to the weight loss and increased caloric expenditure related to his behaviors. The were no other interventions or care plan updates to address R199's hydration status.

Laboratory results dated 10/25/10 included BUN 26 (10 - 26 mg/dl) and Na 145 (135 - 145 meq/l) indicators of hydration status as being on the high end of normal.

On 11/10/10 R199 went to the emergency room post fall for evaluation. The resident blood work was BUN 25 and Na (sodium) 147 (slightly high). There was no evidence that the facility evaluated R199's hydration in response to the elevated

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F 327	Continued From page 38 sodium. On 11/19/10 laboratory results were BUN high at 30 and Na high at 161. A physician's telephone order was obtained on 11/19/10 at 9 PM to start IV of d5 1/2 NSS at 60 ml/hr x 1 liter in response to the blood work. On 11/21/10 laboratory results were BUN 23 and Na still high at 154. Another dose of IV fluids was ordered and administered. On 11/29/10 a physician's order was written to add to the plan of care to encourage resident to consume an extra 240 cc of fluid q shift and document. Interview with a E1 (corporate nurse) on 12/22/10 revealed that all fluids consumed are not documented in the computer and that fluids taken at bedside, in therapy and in activities would not be reflected in these totals. When asked how the nurse evaluated the total intake to ensure the resident is drinking enough she replied that the nurse would ask staff if the resident was drinking enough. An interview with E27 (CNA) on 12/22/10 revealed that a water cup was not kept in R199's room because he was on thickened liquids and needed staff assistance with drinking / eating. She stated that the aides provide him with fluids from prepackaged thickened liquid containers. E27 did reveal that the computer system was new and not all the fluids consumed by the resident were being entered into the system due to a staff learning curve of how to use system and what should be entered.	F 327		

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F 327	Continued From page 39 An interview on 12/22/10 at 10:02 am with E25 (day shift nurse) and E26 (unit manager) revealed the system for monitoring fluid intake/hydration was for the aides to the let the nurses know when the resident is having issues. The nurse then lets the unit manager know and the doctor if necessary. The unit manager passes information that she has received to the dietitian on Mondays and Tuesdays. Since the initiation of computer charting the E5 (ADON) had also been providing food intake and fluid reports to the unit managers on a daily basis. However, there was no evidence in R199's record to support that the staff were addressing the significantly low fluid totals generated by the computer report on a daily basis. Only four nurses notes between 11/1 and 11/20/10 mentioned the encouragement of fluids for R199.	F 327		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to ensure that one (R188) out of 46 sampled residents was free of any significant medication errors. Findings include: During medication pass observation on 12/14/10 at 12:50 PM, E 19 (Licensed Practical Nurse/LPN) administered Depakote (medication to treat the manic episodes associated with bipolar disease) EC (enteric coated) 250 mg. (milligrams) by mouth to R188.	F 333	F333 A) R188 suffered no harm or reaction to the medication error. Discontinued medication was returned to the pharmacy and current medication was administered as ordered. B) All residents have the potential to be affected by this deficient practice. An audit was conducted on all medications stored in the medication carts and compared to the MAR's for any discrepancies. No other discrepancies were found at the time of the audit.	3/11/11

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F 333	Continued From page 40 Review of physician ' s order dated 12/6/10 documented to discontinue Depakote and a new order of Depakote ER (extended release) 250 mg. by mouth three times a day for mood disorder. Review of December 2010 Medication Administration Record (MAR) revealed that R188 was not administered the new medication Depakote ER 250 mg. for a total of 23 administrations for a period of approximately eight days. Review of Depakote ER 250 mg. sent by pharmacy dated 12/6/10 revealed that none of the new medication was administered, thus, the facility continued to administer the discontinued medication. Interview with E18 (Acting Unit Manager and LPN) on 12/14/10 at approximately 5:30 PM confirmed that the resident did not receive any of the new medication. Above findings reviewed with E2 (administrator), E4 (director of nursing), and E17 corporate nurse on 12/23/10 at approximately 2 PM.	F 333	C) When a medication order is changed or discontinued; the medication will be pulled from the medication cart and returned to the Pharmacy or disposed of properly. Education will be provided to all licensed personnel on standards of practice during medication administration. D) Random audits will be conducted weekly times two months of discontinued meds to ensure compliance. The results will be reported monthly to QA.	3/11/11
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interview and test tray evaluations it was determined that the facility failed to ensure that food was palatable and	F 364		

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F 364	Continued From page 41 served at proper temperature. Findings include: 1. On 12/16/10 at 7:00 am cart #1 arrived on the aspen unit. At 7:20 am cart #2 arrived on the aspen unit. A test tray was obtained for both of these carts by the surveyor. The last tray was delivered to a resident on the unit at 8:10 am. The test tray temperatures were: Cart #1 pureed tray Coffee - 116 F cool to taste Milk - 54 F Eggs - 105 F cool to taste with no flavor Oatmeal - 105 cool to taste no flavor Cinnamon Roll - 105 F cool to taste, gummy, rubbery and no flavor Cart #2 regular diet Coffee 121 F cool to taste Milk - 56 F Eggs - 108 F cool to taste Oatmeal - 107 F cool to taste The eggs, oatmeal and coffee on both trays were tested by two surveyors and determined to be unpalatable. The pureed cinnamon roll was tested by two surveyors and found to be unpalatable. An interview on 12/16/10 with E24 (aide) revealed that usually many of the residents are up and out of bed for breakfast however it was not the case that day. It was further revealed that residents who need to be fed are usually seated in the dining room so one staff person can help two residents at the same time. 2. Based on breakfast meal temperatures taken on a test tray at 8:39 AM, on the Sierra unit, on 12-16-10, the temperature of the scrambled eggs	F 364	F364 A) There were no individual or specific residents identified in this finding. B) All residents have the potential to be affected by this deficient practice. An initial audit was conducted to identify issues with palatability and proper temperatures. Initial audit revealed a palatability issue involving thickening agents. C) Kitchen staff was educated in proper procedure for thickening pureed food by the Food Dietary Service Manager. Daily test trays will be conducted of alternating meals by the administrator or designee times 4 weeks then weekly thereafter, to ensure that food is palatable and served at the proper temperature. D) A stop watch audit will be conducted on tray delivery for each unit for 1 meal times 4 weeks. Results from the audit will be reported to QA monthly to ensure compliance.	3/11/11

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F 364	Continued From page 42 was 101.5 degrees F. Upon sampling the eggs, the edges were found to be cold. The delivery time of trays took about 44 minutes from the beginning of service until the last tray was delivered. The test tray was taken after the last tray was served and none of the trays served on the unit were observed to be refreshed or reheated by staff.	F 364	F367 A) R188 suffered no physical harm from consuming a liquid inconsistent with physicians order. The nurse providing the liquid has been educated on the difference between nectar and honey thickened consistencies. B) All residents with swallowing disorders have the potential to be affected by the deficient practice. An audit will be conducted on all residents assessed as a high risk for aspiration with physician orders for thickened consistency liquids. C). Education will be provided by speech therapy to all nursing staff on thickened liquid consistencies and caring for residents with swallowing disorders requiring thickened liquids. D) Random observation audits of nursing staff will be conducted on all units weekly times one month to determine compliance with providing proper consistency of liquids.	3/1/11
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to provide the therapeutic diet prescribed by the physician for one (R188) resident. R188 was administered nectar thickened water and supplement when she had honey thickened liquids ordered. Findings include: Cross refer F333 During medication pass observation on 12/14/10 at 12:50 PM, E19 (Licensed Practical Nurse/LPN) provided R188 lemon flavored water thickened to the consistency of nectar along with Depakote EC 250 mg. (milligrams) pill by mouth to R188. R188 relayed to E19 that she cannot swallow the pill with the water and requested Ensure (liquid nutritional supplement). E19 left the resident with the pill in her mouth unattended for approximately two minutes while obtaining the Ensure. Upon return to R188, E19 poured the Ensure in a cup and placed a straw in the cup for the resident. R188 took one sip from the straw and began to	F 367		

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F 367	Continued From page 43 cough. R188 verbalized that she took the pill to E19. Review of December 2010 Physician ' s Order Sheet (POS) revealed that R188 was prescribed honey thickened liquid due to diagnosis of dysphasia (swallowing difficulty). Interview with E19 at 12:55 AM on 12/14/10 revealed that it was her understanding that R188 was on nectar thickened liquid and she was not aware that the resident was on honey thickened liquid. An additional interview with E21 (Speech Pathologist) on 12/14/10 at 1 PM confirmed that R188 was prescribed honey thickened liquid and not nectar consistency due to R188's increased risk for aspiration. E21 confirmed that the consistency of the Ensure supplement was that of a nectar consistency, thus, the staff failed to thicken the Ensure to the prescribed honey thickened consistency prior to administration to R188. Above findings reviewed with E2 (administrator), E4 (director of nursing), and E17 corporate nurse on 12/23/10 at approximately 2 PM.	F 367	F371 A) There were no individual or specific residents identified in this finding. B) All residents have the potential to be affected by this deficient practice. Bowls were removed from the ready to serve status and cleaned. C) Staff to be educated by the Food Service Director on checking dishes for cleanliness upon removal from dishwasher and prior to using. D) A random audit of dishes in the ready to use status will be conducted weekly times 4 weeks then monthly thereafter. Outcomes will be reported monthly to QA for review and to ensure compliance.	3/4/11
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observations made in the kitchen on 12-9-10, it was determined that the facility failed to store clean dishes under sanitary conditions. Findings include: 1. Two out of eight, white, ceramic bowls reviewed had dried-on food debris on the food contact surfaces. These bowls were stored in ready-to-use status.	F 371	F386 A) R98's pressure ulcers have been evaluated by the NP on 1/7/11 and re-evaluated by the attending physician subsequent to R98's return to the facility. B) All residents have the potential to be affected this deficient practice. An audit has been conducted on all three units based on the Braden Assessment Score to identify those residents at high risk for developing skin breakdown. Appropriate interventions were implemented for those residents identified.	3/11/11
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedures it was determined that the facility failed to ensure that the physician reviewed and assessed pressure ulcers for one (R98) out of 46 residents sampled. Findings include: The facility's policy and procedures for "Pressure ulcers/Skin Breakdown-clinical Protocol" documented " Assessment and Recognition '1. The nursing staff and Attending Physician will	F 386		

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	085020	A. BUILDING _____ B. WING _____	C 12/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 386	Continued From page 45 assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 3. The physician and staff will examine the skin of a new admission for ulcerations or indications of Stage I pressure area that has not ulcerated at the surface. 4. The physician will help the staff define the type (for example, arterial...) and characteristics (necrotic tissue, status of wound bed...) of an ulceration.' Monitoring '1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds.'" Cross refer F314 Review of R98's clinical record revealed he acquired a stage II pressure ulcer on 11/10/10. R98 was hospitalized and readmitted to the facility on 12/10/10 with an unstageable sacral wound and a heel that was black in color with possible deep tissue injury. Review of the wound sheets revealed the facility failed to consistently do weekly skin assessments or weekly measurements or assessments for these wounds. Review of the physician history and physical readmission sheet for 12/13/10 revealed under skin " sacral wound". No other documentation on the progress notes was made. On 12/22/10 at 8:55AM during a telephone interview with E3 (primary physician/medical director) confirmed she failed to observe and assess R98's wounds. She also stated she failed to ensure that wound measurements and assessments were consistently done for R98. E3 continued to state that due to R98's comorbidities	F 386	C) The attending physician will be notified in the event of any newly developed pressure ulcers. The attending physician will also be notified if any existing wound deteriorates or if there is no improvement within two weeks of the same treatment regimen. The attending physician will view any wound(s) that increases to greater than a stage II. Nursing staff will be educated on procedures regarding weekly skin checks with appropriate documentation including assessments and measurements if applicable. D) An audit of wound care documentation, including physician progress notes will be conducted weekly times 12 weeks of any resident with a pressure ulcer. Outcomes and results will be reported at the monthly QA meeting to ensure compliance.	3/11/11

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F 386	Continued From page 46 that included muscle wasting he had unavoidable pressure ulcers.	F 386	F428	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that irregularities reported by the pharmacist for two (R71 and R86) out of 46 sampled residents were acted upon. Findings include: 1. Review of R71's monthly "Consultant Pharmacist Report" dated 11/11/10 noted irregularities identified by E32 (consultant pharmacist). Record review lacked evidence that these were brought to the attention of R71's attending physician, E3. An interview with E4 (director of nursing) on 12/16/10 at approximately 1 PM confirmed that these irregularities were not brought to the attention of E3. Findings reviewed with E2 (administrator), E4 (director of nursing), and E17 corporate nurse on 12/23/10 at approximately 2 PM.	F 428	A) 1) R71 no longer resides in the facility as of 12/11/10. 2) R86 no longer resides in the facility as of 11/22/10. B) All residents have the potential to be affected by this deficient practice. An audit will be conducted of pharmacy consultant reports for the last 3 months. Any irregularity recommendations will be reviewed to determine if the physician responded. Any reports indicating a lack of response will be presented to the physician for review. C) Pharmacy consultant reports will be distributed to each unit manager upon receipt (monthly). Licensed staff will be educated on pharmacy consultant reports and the requirements for follow up with the physician. All reports will be returned by the unit managers within one week to the DON for additional follow up with the attending physician, if applicable. D) An audit of Pharmacy reports will be completed every month for 3 months. Outcomes and results will be reported at the monthly QA meeting to ensure compliance.	3/11/11

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F 428	Continued From page 47 2. Review of R86's monthly "Consultant Pharmacist Report" dated 11/11/10 noted irregularities identified by E32. Record review lacked evidence that these were brought to the attention of R86's attending physician, E3. An interview with E4 (director of nursing) on 12/21/10 at approximately 3 PM confirmed that these irregularities were not brought to the attention of E3. Findings reviewed with E2, E4, and E17 on 12/23/10 at approximately 2 PM.	F 428	F431 A) No residents were identified or affected by this deficient practice. B) All residents have the potential to be affected by this deficient practice. Codes to all med rooms were changed immediately on each unit. C) Licensed nursing staff and CNA's were educated immediately regarding authorization and access restrictions of personnel to medication rooms. Only appropriate licensed nursing personnel will have access codes to the medication rooms at any time. Codes will be changed monthly by the ADON. D) Random observation audits will be conducted weekly times 4 weeks. Outcomes and results will be reported at the monthly QA meeting to ensure compliance.	3/11/11
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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F 431	Continued From page 48 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store all drugs in locked compartments and permit access to only authorized personnel. Findings include: During observation on 12/9/10 from approximately 2 PM to 2:30 PM, two Certified Nursing Assistants, E28 and E29 were observed entering a code in the access pad of the Sierra Unit's medication room door and gaining entry into the room. At approximately 2:36 PM on 12/9/10, the surveyor along with E12 (Sierra Unit Manager/RN) entered the Sierra Unit's medication room and observed the following medications in an unsecured plastic container: Tramadol 50 mg. (26 pills), Cymbalta 30 mg. (30 pills), Seroquel 25 mg. (28 pills), Remeron 15 mg. (22 pills), and Metroprolol 25 mg. (15 pills). Although E12 related to surveyor that only licensed nursing staff are authorized to enter the medication room, the above observations revealed that unauthorized staff had access to the above medications which were not in locked compartments. Above findings reviewed with E2 (administrator), E4 (director of nursing), and E17 corporate nurse	F 431		

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F 431	Continued From page 49 on 12/23/10 at approximately 2 PM.	F 431		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure two residents (R95 and R71) out of 46 residents sampled had accurate information for them to help implement orders prescribed by the physician. Findings include: 1. On 10/12/10 the physician wrote an order for R95 "2. fall mats down on floor while in bed, 3.alarms to bed and chair ...." Review of R95's care plan dated 10/11/10 revised on 10/12/10 stated "At risk for fall related injury as evidence by previous fall related to disease process/condition interventions 10/12/10 fall mats, alarms to bed and chair." Review of the CNA communication Carddex for	F 514	F514 A) 1) R71 no longer resides in the facility as of 12/11/10. 2) R95 no longer resides in the facility 11/6/10. B) All residents have the potential to be affected by the deficient practice. 1) A audit has been completed of all CNA communication Cardex's and any revisions will be made accordingly and as appropriate. 10% of Physician orders have been randomly audited on all three units to determine accuracy. Residents with Cardex concerns identified during audit were addressed accordingly. 2) A10% random audit was conducted on all three units to compare MAR to physician orders. No other residents were affected. C) To ensure that orders are transcribed accurately to the appropriate MAR/TAR, CNA data sheet, nurse will cross reference 24 hour chart check as well as sign the telephone orders everyday. Unit managers will be completing	3/11/11

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F 514	Continued From page 50 R95 revealed there was no documentation indicating the CNAs were informed of the interventions of fall mats and alarms to R95's chair and bed. An interview with E7 (unit manager) on 12/22/10 at 2:10 PM revealed when the physician writes an order it is supposed to be transcribe the order on to the CNA communication Carddex. Then the nurse puts the new order on the 24-hour report sheet. To ensure this is done, the night shift does a 24-hour chart check to ensure all orders are completed and transcribed properly and communicated to the right people. E7 confirmed that the staff failed to ensure R95 orders for fall mats and alarms were communicated to the CNAs through the transcription of the orders to the Carddex, the 24-hour report and ensuring it was completed properly during the 24-hour chart check. 2. Review of R71's December 2010 Physician's Order sheet noted the following orders signed by the attending physician on 12/2/10: -Prandin 2 mg. with meals at 7:30 AM and 12:30 PM on non dialysis days -Prandin 2 mg. with meals at 6 AM and 1 PM on dialysis days. Review of the December 2010 Medication Administration Record revealed that the above medication ordered was administered, in addition, Prandin 2 mg. was administered daily at 5 PM without an order. Interview with E3 (attending physician) on 12/29/10 at 3:40 PM revealed that R71 should have received the 5 PM dose although there was	F 514	monthly medication reviews to ensure physician orders are accurate. D) An audit of 5 charts will be conducted per unit weekly times 3 months. Outcomes and results will be reported at the monthly QA meeting to ensure compliance.	3/11/11

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F 514	Continued From page 51 not an order on the POS.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

IAME OF FACILITY: Pinnacle Rehabilitation & Health Center **DATE SURVEY COMPLETED:** December 23, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint visit was conducted at this facility from December 9, 2010 through December 23, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-eight (138). The survey sample totaled forty-six (46) residents.	Cross Reference F157, F166, F221, F225, F246, F279, F280, F282, F309, F314, F3232, F327, F33, F364, F367, F371, F386, F428, F431, F514 on the 2567
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey	

vider's Signature [signature] Title Administrator Date 1/24/11

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	report date completed 12/23/10, F157, F166, F221,F225, F246, F279, F280, F282, F309, F314, F323, F327, F333, F364, F367, F371, F386, F428, F431, F514.	